Georgia Department Of Community Health
State Health Benefit Plan
Discontinuation of Health Benefit Coverage

Please type or print clearly in ink

I. Member Identification

Social Security Number ___ – ___ – ____

Last Name | First | Initial

Apartment/Box/Route

Street Address

City, State | Zip Code (5-digit + 4-digit)

County of Residence

Date of Birth
Month Day Year

Daytime Telephone Number
( )
Area Code

Sex (Check one)
☐ Male ☐ Female

II. Department Information

Department, Board of Education

Work Unit or School

Please read the Terms, Authorization, Conditions, and Instructions on the back of this form. Check the appropriate statement in Section III. Sign and date this form in Section IV. Your signature certifies that you understand that your subsequent enrollment with the State Health Benefit Plan will be restricted.

III. Discontinuation Reason (Check only one reason)

☐ **Open Enrollment Discontinuation**

During this Open Enrollment period, I choose to discontinue all coverage under the State Health Benefit Plan.

☐ **Discontinuation Due to Coverage through Marriage or Spouse's Employment**

I (and all my eligible dependents) have, within the past 31 days, become eligible for coverage through my spouse's employment. This eligibility is based upon my recent marriage or my spouse's employment (check one):

☐ New employment ☐ Marriage-- Date of Marriage _____ ☐ Open enrollment election

Complete the appropriate section below:

☐ **Spouse's coverage through employment IS under the State Health Benefit Plan**
My spouse's employer, _____, provides health benefit coverage through the State Health Benefit Plan. The contract number (SSN) is _____.

☐ **Spouse's coverage through employment is NOT under the State Health Benefit Plan**
Documentation from the spouse's employer is required and must include date of employment, effective date of coverage, and names of persons covered. Discontinuation will not become effective until documentation is received and approved by the Plan.

☐ **Medicare Discontinuation**

As an active employee who is now eligible for Medicare, I choose to discontinue all coverage with the State Health Benefit Plan. I also understand that in order to have coverage under the SHBP as a retiree, coverage must be in effect at the time of my retirement.

IV. Attestation: I do hereby attest that the above information is true and correct to the best of my knowledge. I further acknowledge and understand that I may be subject to a fine of not more then $1000 or imprisonment for not less than one and no more than five years, or both, if I knowingly and willfully make a false or fraudulent statement or representation to the Department regarding the information reported on this form or other information pursuant to O.C.G.A. Section 16-10-20. I choose to discontinue all coverage, I can not re-enroll until the next open enrollment.

Employee Signature: _____ Date: _____

TERMS, CONDITIONS, AND INSTRUCTIONS

General Information

This form must be completed by a member/employee who discontinues coverage under the State Health Benefit Plan. Review the Statement and Certifications in Section III and sign the appropriate statement.

Enrollment in the State Health Benefit Plan

Enrollment in the State Health Benefit Plan is limited to the Open Enrollment Period, except under the following conditions:

- Upon employment, an employee has the opportunity to **ENROLL** for coverage to begin the first day of the month following completion of one full calendar month of employment, subject to the conditions of the Plan. See the State Health Benefit Plan booklet for pertinent conditions.

- Upon the loss of member's/employee's or dependent's health benefit coverage through Medicaid, Medicare, the group or COBRA coverage of the spouse or former spouse, a member/employee has the opportunity to **ENROLL** for coverage or **CHANGE** from Single to Family coverage provided the request is filed no later than 31 days following the event. *(Attach a letter from Medicaid, Medicare, or the spouse's or former spouse's employer giving the reason the group coverage was terminated, the type of coverage, and the date of coverage termination.)*

- Upon the acquisition of coverage under a new spouse's group plan or your spouse's employment, you may **CHANGE** to Single coverage or **DISCONTINUE** coverage provided all dependents covered under the SHBP contract are covered under the new contract. The request for the change of coverage must be filed within 31 days following the acquisition of coverage. *(Attach a letter from the spouse's employer giving the date of employment, effective date of coverage, and name(s) of person(s) covered.)*

- Upon the acquisition of a dependent by marriage, birth, adoption, a qualified medical child support order (QMCSO) or for certain other changes in family status *(see the Eligible Dependents Section),* a **CHANGE** from Single to Family coverage is allowed provided the request is filed no later than 31 days following the event.

- Upon the loss of all eligible dependents, SHBP will automatically decrease coverage tier to employee only.

Open Enrollment Period

Open Enrollment is a time each year when active employees may enroll or **Change** option or type of coverage without regard to medical underwriting, subject to the provisions of the Plan. Active employees who are eligible to participate in the State Health Benefit Plan shall have an annual Open Enrollment period. The Open Enrollment period consists of a 30-day period beginning no earlier than October 1 and ending no later than Nov 30. Each year in advance of the period, the Commissioner of the Department of Community Health will announce the exact dates.

Note: Retirees may continue coverage at the time of retirement but are not allowed to enroll for coverage.

Authorization I choose to discontinue all coverage under the State Health Benefit Plan. I understand if I discontinue coverage at this time, I cannot re-enroll for coverage under any option of the Plan until the next Open Enrollment Period except under the conditions stated on the reverse of this form.